ES 12-36-07
DBID 780

Notice of Rulemaking Hearing
The Tennessee Department of Human Services
Division of Medical Services

There will be a hearing before the Tennessee Department of Human Services to consider the promulgation of amendments to rules pursuant to Tennessee Code Annotated §§ 4-5-201 et seq. and 71-1-105(12). The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, § 4-5-204 and will take place in the 2nd Floor Board Room, Citizens Plaza Building, 400 Deaderick Street, Nashville, Tennessee 37243 at 1:30 p.m. CDT on Tuesday, February 19, 2008.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Human Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department of Human Services to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department of Human Services' ADA Coordinator, Natasha Webster, Citizens Plaza Building, 400 Deaderick Street, 10th Floor, Nashville, Tennessee 37243, telephone number (615) 313-4731 (TTY)-(800) 270-1349.

For a copy the proposed rule contact: Phyllis Simpson, Assistant General Counsel, Department of Human Services, Citizens Plaza Building, 400 Deaderick Street, 10th Floor, Nashville, TN 37243-1403, telephone number (615) 313-4731.

Substance of Proposed Rules
of
The Tennessee Department of Human Services
Division of Medical Services

Chapter 1240-3-1
General Rules

Amendments

Rule 1240-3-1-.01 Necessity And Function, is amended to delete the obsolete Tennessee Code Annotated reference in the rule so that, as amended, the rule shall read as follows:

1240-3-1-.01 Necessity And Function. The Department of Human Services has responsibility to determine eligibility for medical assistance in accordance with Title XIX of the Social Security Act and Federal regulations. T.C.A. § 71-5-102 empowers the Department to comply with any requirement that may be imposed or opportunity presented by Federal law for the provision of medical assistance to Tennessee's indigent citizenry. Federal regulations set forth definitions for words and/or phrases used by the Department in policies pertaining to the provision of medical assistance. [42 C.F.R. § 435.4].

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-109 and 71-5-111; 42 U.S.C. §§ 1396 et seq.; and 42 C.F.R. § 435.4.

Rule 1240-3-1-.02 Definitions, is amended by adding a new paragraph (2), so that as amended paragraph (2) shall read as follows:

(2) Definitions of terms or phrases utilized in Medicaid Spenddown, Standard Spend Down and TennCare Standard.

(a) Call-in Line. The toll-free telephone single point of entry used during a period of open enrollment (as announced by the Bureau of TennCare) to enroll new applicants in the Standard Spend Down Program (SSD).

(b) Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living.

(c) Continuous eligibility. Enrollment in a Medicaid Medically Needy, Standard Spend Down or TennCare Standard eligibility category with no break in coverage.

(d) Continuous enrollment. Certain individuals determined eligible for the TennCare Program may enroll at any time during the year. Continuous enrollment is limited to persons in the following two (2) groups:

1. TennCare Medicaid enrollees

2. Individuals who are losing their Medicaid, who are uninsured, who are under 19 years of age, and who meet the qualifications for TennCare Standard as "Medicaid Rollovers" in accordance with the provisions of these rules.

(e) Open enrollment. A designated period of time determined by the Bureau of TennCare,

during which individuals may apply for enrollment in TennCare Standard or Standard Spend Down.

1. The following individuals may apply for TennCare Standard as uninsured or medically eligible persons during a period of open enrollment:

   (i) Uninsured individuals whose incomes fall within the poverty levels established for the period of open enrollment being held;

   (ii) Individuals qualifying as medically eligible as defined in these rules and whose incomes fall within the poverty levels established for the period of open enrollment being held.

2. Individuals applying for the Standard Spend Down Program may apply during a period of open enrollment announced by the Bureau of TennCare in accordance with these rules.

(f) Standard Spend Down. The demonstration category composed of adults aged twenty-one (21) and older who are not eligible for Medicaid but who meet the requirements for Standard Spend Down that are outlined in these rules and those of the TennCare Bureau.

(g) TennCare Standard. That part of the TennCare program which provides coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules and those of the TennCare Bureau.

(h) Transition Group. Existing Medically Needy Adults or non-pregnant, non-postpartum adults twenty-one (21) or older enrolled as medically needy as of July 1, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults twenty-one (21) or older.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-101, 71-5-103, and 71-5-111; 42 USC §§ 1395 et seq., and 42 U.S.C. §§ 1396 et seq. and TennCare II Medicaid Section 1115 Demonstration Waiver.

Substance of Proposed Rules
of
The Tennessee Department of Human Services
Division of Medical Services

Chapter 1240-3-2
Coverage Groups Under Medicaid

Amendments

Rule 1240-3-2-.01 Necessity And Function, is amended to delete the obsolete Tennessee Code Annotated reference in the rule so that, as amended, the rule shall read as follows:

1240-3-2-.01 Necessity And Function. The Department of Human Services has responsibility to determine eligibility for medical assistance in accordance with Title XIX of the Social Security Act. T.C.A. §§ 71-5-102, 71-5-104 and 71-5-106 empower the Department to comply with any requirement that may be imposed or opportunity presented by Federal law for the provision of medical assistance in Tennessee. Federal regulations set forth the mandatory and optional groups of the Medicaid Program [42 C.F.R. §§ 435.100, 435.200 and 435.300].

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-104, 71-5-106, 71-5-109 and 71-5-111; 42 U.S.C. §§ 1396 et seq.; and 42 C.F.R. §§ 435.100, 435.200 and 435.300.

Rule 1240-3-2-.02 Coverage Of The Categorically Needy, is amended by deleting subparagraphs (c), (e), (f), (k), (n) and (q) under paragraph (2) in their entireties, and by substituting the following language instead, so that, as amended subparagraphs (2)(c), (e), (f), (k), (n) and (q) shall read as follows:

(c) Any Social Security beneficiary who would be currently eligible for Families First/AFDC or SSI if the Social Security increase in September, 1972, was disregarded, provided:

1. He received Old Age Assistance (OAA), Assistance for the Blind (AB), Assistance for the Disabled (AD), or Aid For Dependent Children (AFDC) in August 1972; and

2. Was also entitled to Social Security monthly benefits for August 1972.

(e) Any aged, blind, or disabled (AABD) individual who loses eligibility for Supplemental Security Income (SSI) benefits due to a Social Security (Title II) cost of living increase beginning in July 1977, but who would be eligible for SSI if cost of living adjustments received since their SSI termination were disregarded.

(f) Any aged, blind, or disabled (AABD) individual institutionalized in a medical institution (i.e., one organized to provide medical care or in Home and Community-Based Services (HCBS) under a waiver pursuant to 1915(c) of the Social Security Act [42 U.S.C. § 1396n(c)]) who has income equal to or less than three hundred percent (300%) of the SSI Federal Benefit Rate and who meet all applicable technical and financial eligibility criteria.

(k) Pregnant women and infants up to one (1) year old who meet the income standards based on one hundred eighty-five percent (185%) of the federal poverty guidelines for the family size. If an application is made no later than delivery date and the pregnant woman is eligible at any time during the application processing period, eligibility

continues without regard to income changes throughout the pregnancy. Eligibility continues for the pregnant woman two (2) full calendar months after the month pregnancy ends regardless of changes in the pregnant woman's eligibility status. A woman eligible under this subparagraph will receive full coverage in addition to pregnancy-related services. For purposes of this subparagraph, "pregnancy-related services" may mean any service eligible for coverage under the Medicaid program that potentially affects the pregnancy.

(n) Effective January 1, 1998, individuals who meet eligibility requirements for Special Low Income Beneficiaries (SLIB) except that income is greater than one hundred twenty percent (120%) of federal poverty guidelines, but not greater than one hundred thirty five percent (135%) may be eligible for state buy-in of Part B Medicare premiums, if not currently eligible for or receiving Medicaid or TennCare on "first come, first served" basis up to the State's allocation of federal funds. This group is referred to as Qualifying Individuals 1 (QI1).

(q) Pregnant women who meet the applicable income levels for the categorically needy (i.e., those whose total income does not exceed one hundred eighty-five percent (185%) of the Federal poverty guidelines and who are determined eligible by a qualified provider for a presumptive eligibility period in accordance with Section 1920 of the Social Security Act) are eligible for ambulatory prenatal services. Only one (1) presumptive period of eligibility is allowed for each pregnancy.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; Acts 2007, Chapter 31 § 11; 8 U.S.C. §§ 1611, 1612, 1613 and 1641, 42 U.S.C. § 423 note, 42 U.S.C. § 608(a)(2), 42 U.S.C. § 608(a)(6), 42 U.S.C. § 608(a)(11), 42 U.S.C.§ 672(h), 42 U.S.C. § 673(b), 42 U.S.C. § 1315, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(i), 42 U.S.C. § 1396a(a)10(A)(i)(1V), 42 U.S.C. § 1396a(a)(10)(E); 42 U.S.C. § 1396a(e)(1)(A), 42 U.S.C. § 1396a(e)(4)(5) and (6), 42 U.S.C. 1396a(l)(1)(D), 42 U.S.C. § 1396a(aa), 42 U.S.C. 1396b(v)(1), 42 U.S.C. § 1396n(c), 42 U.S.C. § 1396r, 42 U.S.C. § 1396r-6, 42 U.S.C.§ 1396u-1; 42 C.F.R. §§ 435.4, 435.100, 42 C.F.R. 435.200, and 42 C.F.R. 435.831; PL 94-566 §503; PL 98-21 §134; PL 99-509 §9401; PL 100-203 §9116; PL 101-508 §5103(e), PL 104-193 §§103 and 431 and PL 109-171 § 6036 and 7101; and 71 FR 39214 (July 6, 2006).

Rule 1240-3-2-.02 Coverage of the Categorically Needy, is amended by deleting subparagraph (p) of paragraph (2) in its entirety and by substituting instead the following language so that, as amended, subparagraph (p) of paragraph (2) shall read as follows:

(p) Legal aliens; immigrants who are not age sixty-five (65) or older, blind, disabled, or under age eighteen (18); undocumented aliens; and other aliens who do not have permanent resident status, including illegal aliens as specified under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and the Deficit Reduction Act of 2005 (DRA), if otherwise eligible, may qualify for emergency medical services where the individual has a medical condition, including emergency labor and delivery, manifested by acute symptoms of sufficient severity which, if not attended to immediately, could reasonably be expected to result in placing the patient's health in serious jeopardy, severe impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; 8 U.S.C. §§ 1611, 1612, 1613, and 1641, 42 U.S.C. § 423 note, 42 U.S.C. § 608(a)(2), 42 U.SC. § 608(a)(11), 42 U.S.C. § 1315, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(i), 42 U.S.C. § 1396a(a)10(A)(i)(IV), 42 U.S.C. § 1396a(a)(10)(E), 42 U.S.C. § 1396a(e)(1)(A), 42 U.S.C. § 1396a(e)(4)(5) and (6), 42 U.S.C. § 1396a(l)(1)(D), 42 U.S.C. § 1396a(aa), 42 U.S.C. § 1396b(v)(1), 42 U.S.C. § 1396n(c), 42 U.S.C. § 1396r, 42 U.S.C. § 1396r-6, and 42 U.S.C. § 1396u-1; 42 C.F.R. §§ 435.4, 435.100, 435.200, and

435.831; PL 94-566 § 503, PL 98-21 § 134, PL 99-509 § 9401, PL 100-203 § 9116, PL 101-508 § 5103(e), PL 104-193 § 431, and PL 109-171 § 6036; and 71 FR 39214 (July 6, 2006).

Rule 1240-3-2-.02 Coverage of the Categorically Needy, is amended by adding a new subparagraph (x) so that, as amended, subparagraph (x) of paragraph (2) shall read as follows:

(x) Women who have been found to have breast or cervical cancer including a precancerous condition, through the National Breast and Cervical Cancer Early Detection Program, who are under age sixty-five (65) and are uninsured and not otherwise eligible for Medicaid or receiving TennCare Standard are eligible to receive Medicaid in the Breast and Cervical Cancer category.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; Acts 2007, Chapter 31 § 11; 8 U.S.C. §§ 1611, 1612, 1613 and 1641, 42 U.S.C. § 423 note, 42 U.S.C. § 608(a)(2), 42 U.S.C. § 608(a)(6), 42 U.S.C. § 608(a)(11), 42 U.S.C. § 1315, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(i), 42 U.S.C. § 1396a(a)10(A)(i)(1V), 42 U.S.C. § 1396a(a)(10)(E); 42 U.S.C. § 1396a(e)(1)(A), 42 U.S.C. § 1396a(e)(4)(5) and (6), 42 U.S.C. 1396a(l)(1)(D), 42 U.S.C. § 1396a(aa), 42 U.S.C. 1396b(v)(1), 42 U.S.C. § 1396n(c), 42 U.S.C. § 1396r, 42 U.S.C. § 1396r-6, 42 U.S.C.§ 1396u-1; 42 C.F.R. §§ 435.4, 435.100, 42 C.F.R. 435.200, and 42 C.F.R. 435.831; PL 94-566 §503; PL 98-21 §134; PL 99-509 §9401; PL 100-203 §9116; PL 101-508 §5103(e), PL 104-193 §§103 and 431 and PL 109-171 § 6036 and 7101; and 71 FR 39214 (July 6, 2006).

Rule 1240-3-2.03 Coverage of the Medically Needy, is amended by deleting the rule in its entirety and by substituting the following language, so that, as amended, the rule shall read as follows:

1240-3-2-.03 Coverage of The Medically Needy. The following groups of medically needy individuals, if otherwise eligible, are covered:

(1) Pregnant women in one or two-parent families who, but for income and resources, would be eligible as Categorically Needy (Families First/AFDC) and who meet the Medically Needy financial requirements shall remain eligible without regard to income changes and for two (2) full calendar months of postpartum coverage regardless of changes in circumstances.

(2) Aged, blind and disabled non-pregnant individuals age twenty-one (21) and older are no longer eligible for coverage as Medically Needy. Effective April 30, 2005 enrollment in the Medically Needy Category was closed to new enrollees except for children under age twenty-one (21) and pregnant women. Currently eligible Medically Needy Adults will be given the opportunity to apply for Standard Spend Down. Individuals who are subsequently approved will be given coverage for a period of twelve (12) months from their begin date.

(a) Prior to actual enrollment in Standard Spend Down, the Transition Group enrollees were looked at for eligibility in an open category of Medicaid through the ex parte review process. Transition Group enrollees not found eligible in an open category of Medicaid, will be selected for Standard Spend Down processing through the Request for Information (RFI) process.

(3) Children under age twenty-one (21), Caretaker.

(a) All children under age twenty-one (21) who meet the Medically Needy technical and financial eligibility requirements. The caretaker of such children is also covered if:

1. The caretaker is pregnant; or

2. The caretaker is under age twenty-one (21).

(b) Both parents of a dependent child, if both parents are under age twenty-one (21) may be covered, if otherwise eligible.

(c) Newborns of women in one or two-parent families are covered effective from date of birth and continue as long as the child is living with the mother and the mother is Medicaid eligible or if she would be Medicaid eligible, if she were pregnant, up to one (1) year.

(4) Pregnant women and children under twenty-one (21) are classified as Exceptional Medically Needy or Spenddown Medically Needy. Persons are exceptional Medically Needy if eligibility is due to their regular monthly income being equal to or below the medically needy eligibility standards.

(5) Whenever a pregnant woman or child under twenty-one (21) has income which prevents their qualifying as Exceptional Medically Needy eligibility on the basis of income, spenddown eligibility is determined pursuant to these rules.

(6) Individuals who meet Standard Spend Down (SSD) criteria:

(a) Tennessee residents who have been determined to be eligible for the Standard Spend Down (SSD) program.

(b) Individuals enrolled must meet the following criteria:

1. Must be aged twenty-one (21) or older;

2. Must not be pregnant; or

3. Must meet one of the following criteria:

(i) Be sixty-five (65) years of age or older, or

(ii) Be blind, as defined in rule 1240-3-3-.02(3); or

(iii) Be disabled, as defined in rule 1240-3-3-.02(4); or

(iv) Be a "caretaker relative" of a Medicaid-eligible dependent child as defined in T.C.A. § 71-3-153; and

4. Must meet the financial eligibility criteria for income and resources that apply to Medically Needy pregnant women and children eligible under the State plan. These criteria are found at rules 1240-3-3-.05 and 1240-3-3-.06.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106 and 71-5-109; 42 U.S.C.§ 1315, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii), and 42 USC §1396a(e)(4) and (1)(1);.42 C.F.R. § 435.831, 42 C.F.R. § 435.210 and 42 C.F.R. § 435.201; PL 100-485 § 401; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Rule 1240-3-2-.04 Repealed, is amended by renaming the rule " Enrollment For Standard Spend Down Individuals ", amending the Table of Contents accordingly, and by inserting the following language so that, as amended, the rule shall read as follows:

1240-3-2-.04 Enrollment For Standard Spend Down Individuals.

(1) Transition Group enrollees not found eligible in an open category of Medicaid, will be selected for Standard Spend Down processing through the Request for Information (RFI)

process. The TennCare waiver gives the State the authority to establish an enrollment cap and to limit open enrollment periods to the number of individuals who can be admitted under the cap.

(2) Categories for enrollment in the Standard Spend Down (SSD) program are as follows:

(a) Category 1. People who are not eligible for Medicaid at the time the SSD program is implemented and who meet the criteria for the new SSD program. (Bureau of TennCare will announce open enrollment for SSD).

(b) Category 2. People who, at the time the SSD program is implemented, are eligible for Medicaid in a non-pregnant adult Medically Needy category, who have completed their twelve (12) months of Medicaid eligibility, who have been found to be ineligible for any other Medicaid category, and who have been determined to meet the criteria of the SSD program.

(3) Applicants in the above categories will be enrolled as follows:

(a) Category 1 (applicants who will be allowed to apply when announced by the Bureau of TennCare) will be enrolled only through a single toll-free telephone point of entry (the Call-in Line) initiated in periods of acceptance of new applications. In each open enrollment period, the State will determine a specified number of calls that it will accept through the Call-in Line based on the number of Category 1 applications that, together with projected pending applications from Category 2, the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in open enrollment periods will also be based on the number of remaining slots available under the enrollment target and the number of slots necessary to reserve for non-pregnant Medically Needy adults in Category 2. The State will not accept or track calls received outside of open enrollment periods.

(b) For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their termination from Medicaid, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be accepted in the SSD category.

Upon implementation of the SSD program, the State will review all Category 2 individuals for either eligibility in a new Medicaid category or approval as a Standard Spend Down eligible. After the review of all Category 2 individuals is complete and it is determined how many additional enrollees can be added to the SSD program without exceeding the enrollment cap, the State will begin enrolling persons in Category 1.

(4) New open enrollment periods as announced by the Bureau of TennCare. Once the State has reached its targeted enrollment, new open enrollment periods will be scheduled when enrollment in the SSD program drops to ninety percent (90%) of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-in Line have been received. The number of calls to be received will be based on the State's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

(5) Initial application period for Category 1 (as announced by the Bureau of TennCare).

The State will establish an initial target enrollment figure based on the State's determination of the minimum number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions. A toll-free Call-in Line to receive requests for applications will be established and requests will be processed as follows:

(a) Callers to the Call-in Line will be asked for basic demographic information and will be assigned a unique identifier.

(b) After conducting a match to verify that callers are not already enrolled in TennCare Medicaid and if they are not Medicaid-eligible, the State will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within thirty (30) days. (Those callers who are already enrolled in TennCare Medicaid will be sent letters advising them that they currently have benefits and need not apply.)

(c) Completed signed applications received by the State by the 30-day deadline established by the State will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the State does not receive an application by the deadline, the State will send the individual a letter advising him or her that since no application was received, the State will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline.

(d) Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 C.F.R. 435.911; such timeframes will begin on the date a signed written application is received by the State.

(6) Effective date of eligibility. The effective date provisions outlined below only apply to SSD eligibility and do not apply to other categories of TennCare eligibility.

(a) The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-in Line and who submit a timely signed application will be the later of:

1. The date that their call was received by the Call-in Line; or

2. The date spenddown is met (which must be no later than the end of the one month budget period – in this case, the end of the month of the original call to the Call-in Line).

(b) The effective date of eligibility for Medically Needy pregnant women and children under age twenty-one (21) is the later of:

1. The date of application; or

2. The date that spenddown is met – in this case, the end of the month that the application is received by the Department of Human Services.

(7) Period of eligibility. All enrollees in the SSD demonstration category will have an eligibility period of twelve (12) months from the effective date of the eligibility. At the end of the 12-month period the enrollee will need to have his eligibility redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for Medically Needy pregnant women and children in TennCare Medicaid.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(12), 71-5-102 and 71-5-109; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii), 42 U.S.C. § 1396a(e)(4) and 42 U.S.C. § 1315; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Substance of the Proposed Rules
of
The Tennessee Department of Human Services
Division of Medical Services

Chapter 1240-3-3
Technical And Financial Eligibility
Requirements For Medicaid

Amendments

Rule 1240-3-3-.01 Necessity And Function, is amended to delete the obsolete Tennessee Code Annotated reference in the rule and to replace the word "administer" with the words "determine eligibility" so that, as amended, the rule shall read as follows:

1240-3-3-.01 Necessity And Function. The Department of Human Services has responsibility to determine eligibility for medical assistance in accordance with requirements of Title XIX of the Social Security Act. T.C.A. §§ 71-5-102, 71-5-104 and 71-5-106 empower the Department to comply with any requirement that may be imposed or opportunity presented by Federal law for the provision of medical assistance to Tennessee's indigent citizenry. Federal regulations set forth the resource and income standards and the technical requirements by which eligibility for Medicaid is determined. [42 C.F.R. §§ 435.400, 435.500, 435.600, 435.700 and 435.800].

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-104, 71-5-106, 71-5-109 and 71-5-111; 42 C.F.R. §§ 435.400, 435.500, 435.600, 435.700 and 435.800; and 42 U.S.C. §§ 1396 et seq.

Rule 1240-3-3-.02 Technical Eligibility Factors, is amended by deleting paragraph (5) in its entirety and by substituting instead the following language so that, as amended, paragraph (5) shall read as follows:

(5) An individual must be a citizen of the United States, a naturalized citizen, certain American Indians born outside of the United States, or a qualified alien, unless applying for emergency medical services assistance as an illegal or undocumented alien or one lawfully admitted for residence who is not aged, blind, disabled, or under age eighteen (18). Aliens who entered the United States on or after August 22, 1996 have a five (5) year bar before potential eligibility for TennCare Medicaid unless they meet the exceptions to the five (5) year bar as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

(a) Each applicant/recipient is required to provide documentary evidence of citizenship and identity when applying for medical assistance. This requirement shall not apply to an individual declaring to be a citizen or national of the United States if they are:

1. A recipient of Medicare; or

2. A recipient of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI); or

3. A child who is a recipient of foster care or adoption assistance under Title IV-B of the Social Security Act; or

4. A child who is a recipient of foster care or adoption assistance under Title IV-E of the Social Security Act.

(b) All documents must be originals or certified by the issuing agency.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, 71-5-107, 71-5-109, 71-5-120, and 71-5-141; 8 U.S.C. §§ 1611, 1612, 1613, and 1641, 42 U.S.C. § 402, 42 U.S.C. § 423, 42 U.S.C. § 672, 42 U.S.C. §673, 42 U.S.C. § 1315, 42 U.S.C. § 1382c(a)(3) and (4), 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii)(I)(V) and (VI), 42 U.S.C. § 1396b(v)(1) and (x)(1), (2) and (3), 42 U.S.C. § 1396d and 42 U.S.C. 1396n(c); 42 C.F.R. §§ 435.210, 435.300, 435.301, 435.403, 435.406, 435.407, 435.530, and 435.540, 435.622 and 42 C.F.R. § 435.914(c); PL 104-193 §§ 401, 402, 403, and 431, PL 109-171 § 6036; 71 FR 39214 (July 6, 2006); PL 109-432, Division B, Title IV § 405, December 20, 2006; and TennCare Medicaid Section 1115 Demonstration Waiver.

Rule 1240-3-3-.02 Technical Eligibility Factors, is amended by inserting the following language as a new paragraph (6) and renumbering the remaining paragraphs accordingly, so that, as amended, the new paragraph (6) shall read as follows:

(6) A child up to age twenty-one (21) or a pregnant woman.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, 71-5-107, 71-5-109, 71-5-120, and 71-5-141; 8 U.S.C. §§ 1611, 1612, 1613, and 1641, 42 U.S.C. § 402, 42 U.S.C. § 423, 42 U.S.C. § 672, 42 U.S.C. §673, 42 U.S.C. § 1315, 42 U.S.C. § 1382c(a)(3) and (4), 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii)(I)(V) and (VI), 42 U.S.C. § 1396b(v)(1) and (x)(1), (2) and (3), 42 U.S.C. § 1396d and 42 U.S.C. 1396n(c); 42 C.F.R. §§ 435.210, 435.300, 435.301, 435.403, 435.406, 435.407, 435.530, and 435.540, 435.622 and 42 C.F.R. § 435.914(c); PL 104-193 §§ 401, 402, 403, and 431, PL 109-171 § 6036; 71 FR 39214 (July 6, 2006); PL 109-432, Division B, Title IV § 405, December 20, 2006; and TennCare Medicaid Section 1115 Demonstration Waiver.

Rule 1240-3-3-.03 Resource Limitations For Categorically Needy, is amended by inserting the words "Families First" in front of the words "AFDC" and by replacing the obsolete State rule references in paragraph (1) so that, as amended, paragraph (1) shall read as follows:

(1) Applicants for medical assistance as Categorically Needy in an AFDC related coverage group are permitted to retain resources as described in rule 1240-1-50-.02 pertaining to the Families First/AFDC cash assistance program. Excluded resources are those excluded in the Families First/AFDC cash assistance program as reflected in rule 1240-1-50-.05 and countable resources are determined by using the Families First/AFDC policy reflected in rule 1240-1-50-.06. Lump sum payments are treated as income in the month of receipt and a resource if retained thereafter.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202 and 71-1-105(12); 42 U.S.C. §§ 1396 et seq.; 45 C.F.R. § 233.20 and 20 C.F.R. § 416.1205.

Rule 1240-3-3-.03 Resource Limitations For Categorically Needy, is amended by deleting the phrase Qualifying Individuals 2 in paragraph (2) so that, as amended, paragraph (2) shall read as follows:

(2) Applicants for medical assistance as Categorically Needy in an SSI-related category are permitted to retain resources in an amount not to exceed SSI limits except for Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLIMBs), Special Low Income Beneficiaries (SLIBs) Qualifying Individuals 1 (QI1), and Qualified Disabled Working Individuals who are permitted to retain resources in an amount not to exceed two hundred percent (200%) of the SSI limits.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. §§ 435.700,

435.721(b), 435.725, 435.735, 435.831, 435.832 and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by deleting subpart (i) of paragraph (2), subparagraph (a), part 1 in its entirety and by substituting instead the following language so that, as amended, subpart (i) shall read as follows:

(i) A homestead may be exempt if used as a home by the applicant/recipient, spouse, and/or dependent/relative. If absent from the home with intent to return, an individual may retain a homestead for an unlimited period of time. Based on current market values, individuals with an equity interest in their home greater than five hundred thousand dollars ($500,000) are ineligible for Medical assistance for either institutional care or Home and Community-Based Services (HCBS). Beginning in the year 2011, the five hundred thousand dollar ($500,000) limit on home equity will increase each year. The increase will be based on the percentage increase in the Consumer Price Index (CPI) for all urban consumers, rounded to the nearest one thousand dollars ($1,000).

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(e), 42 U.S.C. § 1396p(f)(1), (2) and (3), 42 U.S.C. § 1396p(g), and 42 U.S.C. § 1396r-5(b), (d), (f) and (g); 42 C.F.R. §§ 435.700, 435.721(b), 435.831 and 435.914 (b) and (c); 20 C.F.R. § 416.1205(c) and 20 C.F.R. §§ 416.1212, 416.1220 and 416.1224; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993; and PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9, PL 104-193, and PL 109-171 §§ 6011, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations For Categorically Needy, is amended by inserting the numbers with the figures in paragraph (2), subparagraph (a), part 1, subpart (ii), so that as amended paragraph (2), subparagraph (a), part 1, subpart (ii) shall read as follows:

(ii) All life insurance, if the total face of all policies does not exceed fifteen hundred dollars ($1500) per owner.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. §§ 435.700, 435.721(b), 435.725, 435.735, 435.831, 435.832 and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations For Categorically Needy, is amended by inserting a dash between the words forty and six in paragraph (2), subparagraph (a), part 1, subpart (iii), item (IV), subitems I and II and to change the rule cite in the second sentence to read 1240-3-3-.03(2)(a)1(iii), so that as amended paragraph (2), subparagraph (a), part 1, subpart (iii), item (IV), subitems I and II shall read as follows:

(iii) One motor vehicle of unlimited value is excluded in its entirety, if it meets any one of the following conditions:

(I) It is necessary for employment; or

(II) It is necessary to obtain medical treatment of a specific or regular medical problem; or

(III) It has been modified for operation by or transportation of a handicapped person; or

(IV) It is necessary because of climate, terrain, distance, or similar factors to provide transportation to perform essential daily activities.

I. If no motor vehicle is excluded under the above provisions, one motor vehicle is excluded to the extent equity value does not exceed forty-six hundred dollars ($4,600). If the equity value exceeds forty-six hundred dollars ($4,600), the excess is counted against the resource limit.

II. The equity value of any other motor vehicle is counted unless also excludable under 1240-3-3-.03(2)(a)1(iii) above or qualified as property under an approved plan for self-support or necessary for self-support in a business or non-business income producing activity. If no motor vehicle is excluded under the above provisions, one motor vehicle is excluded to the extent equity value does not exceed forty-six hundred dollars ($4,600). If the equity value exceeds forty- six hundred dollars ($4,600), the excess is counted against the resource limit.

III. The equity value of any other motor vehicle is counted unless qualified as property under an approved plan for self-support or necessary for self-support, in a business or non-business income producing activity, or fifteen hundred dollars ($1,500) of the equity value is set aside for burial reserve.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. §§ 435.700, 435.721(b), 435.725, 435.735, 435.831, 435.832 and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations For Categorically Needy, is amended by deleting subpart (v) of paragraph (2), subparagraph (a), part 1 in its entirety and by substituting instead the following language so that, as amended, subpart (v) shall read as follows:

(v) Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools etc.) used in a trade or business; nonbusiness income-producing property (such as, houses or apartments for rent, land other than home property, etc.); and property used to produce goods or services

essential to an individual's daily activities. Liquid resources other than those used as a part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualified under the home exclusion (1240-3-3-.03(2)(a)1(i) above), it is not considered in evaluating property essential to self-support.

(I) Property used in a trade or business or nonbusiness income-producing activity.

I. When property is used in a trade or business or nonbusiness income-producing activity, only the individual's (or spouse, if any) equity in the property is counted. Exclude as essential for self-support up to six thousand dollars ($6,000) in equity and count only the amount that exceeds six thousand dollars ($6,000), if the net income totals at least six percent (6%) of the equity.

II. If the work activity produces less than a six percent (6%) rate of return due to circumstances beyond the individual's control such as due to illness or crop failure and the individual is expected to resume the activity, the equity up to six thousand dollars ($6,000) continues to be excluded. If the individual's total equity in the property is producing six percent (6%) income but is over the six thousand dollars ($6,000) equity limit, the amount of equity exceeding the six thousand dollars ($6,000) is counted as a resource.

III. If the individual owns more than one (1) piece of property and each produces income, each is looked at to see if the six percent (6%) rule is met and then the amounts of the individual's equity in all of those properties producing six percent (6%) are totaled to see if the total equity is six thousand dollars ($6,000) or less. The equity in those properties that do not meet the six percent (6%) rule is counted toward the allowable resource limit of two thousand dollars ($2,000) for an individual. If the total equity in the properties producing six percent (6 %) income is over the six thousand dollars ($6,000) equity limit, the amount of equity exceeding six thousand dollars ($6,000) is counted as a resource toward the allowable resource limit.

Example: Charlotte operates a farm. She owns 3 acres of land on which her home is located. She also owns 10 acres of farm land not connected to her home. There are 2 tool sheds and 2 animal shelters located on the 10 acres. She has various pieces of farm equipment that are necessary for her farming activities. We exclude the house and the 3 acres under the home exclusion (20 C.F.R. § 416.1212). However, we look at the other 10 acres of land, the buildings and equipment separately to see if her total equity in them is no more than $6,000 and if the annual rate of return is 6 percent of her equity. In this case, the 10 acres and buildings are valued at $4,000 and the few items of farm equipment and other inventory are valued at $1,500. Charlotte sells produce which nets her more than 6 percent

for this year. The 10 acres and other items are excluded as essential to her self-support and they continue to be excluded as long as she meets the 6-percent annual return requirement and the equity value of the 10 acres and other items remains less than $6,000.

Additional Example: At redetermination, Mr. Jones (the community spouse) states he now lives in an apartment and has rented the couple's formerly excluded homestead which has an equity value of $10,000. Although, the property produces a 6% rate of return, $4,000 of its equity cannot be excluded under this subpart (v).

(II) Property that represents government authority to engage in an income-producing activity.

I. Property that represents the authority granted by a governmental agency to engage in an income-producing activity is excluded as property essential to self-support if it is used in a trade or business or nonbusiness income-producing activity or not used due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.

Example: John owns a commercial fishing permit granted by the State Commerce Commission, a boat and fishing tackle. The boat and tackle have an equity value of $6,500. Last year, John earned $2,000 from his fishing business. The value of the fishing permit is not determined because the permit is excluded under the exception. The boat and tackle are producing in excess of a 6 percent return on the excluded equity value, so they are excluded up to $6,000. The $500 excess value is counted toward the allowable resource limit of $2,000 for an individual.

(III) Property required by employer.

I. Personal property required by the individual's employer for work is not counted regardless of value, while the individual is employed. Examples of this type of personal property include tools, safety equipment, uniforms and similar items.

(IV) Property used to produce goods or services essential to daily activities.

I. Nonbusiness property is considered to be essential for an individual's (and spouse, if any) self-support if it is used to produce goods or services necessary for his or her daily activities. This type of property includes real property such as land which is used to produce vegetables or livestock only for personal consumption in the individual's household (for example, corn, tomatoes, chicken, cattle). Property used to produce goods or services or property necessary to perform daily functions is excluded if the individual's

equity in the property does not exceed six thousand dollars ($6,000).

For example: Bill owns a small unimproved lot several blocks from his home. He uses the lot, which is valued at $4,800, to grow vegetables and fruit only for his own consumption. Since his equity in the property is less than $6,000, the property is excluded as necessary to self-support.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. §§ 435.700, 435.721(b), 435.725, 435.735, 435.831, 435.832 and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by inserting a new subpart (vii) under paragraph (2), subparagraph (a), part 1 and by renumbering the existing subparts (vii) and (viii) respectively as (viii) and (ix) so that, as amended, the newly designated subpart (vii) shall read as follows:

(vii) Funds used to purchase a promissory note, loan or mortgage, if the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan with no deferrals or balloon payments, and the balance is not cancelled upon the death of the lender.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(e), 42 U.S.C. § 1396p(f)(1), (2) and (3), 42 U.S.C. § 1396p(g), and 42 U.S.C. § 1396r-5(b), (d), (f) and (g); 42 C.F.R. §§ 435.700, 435.721(b), 435.831 and 435.914 (b) and (c); 20 C.F.R. § 416.1205(c) and 20 C.F.R. §§ 416.1212, 416.1220, and 416.1224; Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993; and PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9, PL 104-193 and PL 109-171 §§ 6011, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by inserting the numbers with the figures in paragraph (2), subparagraph (b) and to change the rule cite, so that as amended, paragraph (2), subparagraph (b) shall read as follows:

(b) In SSI related cases all other resources such as, but not limited to bank accounts, money on hand, stocks, bonds, cash value of life insurance on which the total face value exceed fifteen hundred dollars ($1,500), real property, other than income-producing and homestead property (including cemetery plots) not exempt in 1240-3-3-.03(2)(a)1(i) and (v), non-excluded motor vehicles and revocable burial agreements, unless exempt as in 1240-3-3-.03(2)(a)1(iii) and (viii) shall be counted toward the resource limit per family size.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6)

and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. §§ 435.700, 435.721(b), 435.725, 435.735, 435.831, 435.832 and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (3) in its entirety and by substituting instead the following language so that, as amended, paragraph (3) shall read as follows:

(3) Transfer of Assets.

(a) Countable assets under this paragraph (3) include all real and personal property except a home and title transferred to the individual's--

1. Spouse;

2. Minor child under age twenty-one (21) or adult disabled or blind child;

3. Sibling who has equity interest in the property and has resided in the home for at least one (1) year prior to the individual's institutionalization;

4. Child [other than those in part 2 above] who resided in the home at least two (2) years immediately preceding the individual's institutionalization and who provided care that permitted the individual to stay in the home rather than a medical or nursing facility; or

5. To another for the sole benefit of the community spouse or the individual's child who is blind or permanently and totally disabled, or under age twenty-one (21).

(b) The period of ineligibility for nursing home vendor or waivered services under HCBS for assets transferred within sixty (60) months of application for long term care nursing services or HCBS will be determined by dividing the uncompensated value of the transferred asset by the average monthly nursing home private pay rate. In determining the penalty for a transfer a State may not round down or disregard any fractional period of ineligibility. There is no limit on the maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist and the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations and the application of the penalty will result in loss of essential nursing care, which is not available from any other source.

(c) If an asset has been found to be transferred for less than fair market value within the sixty (60) month look-back period, the penalty period begins the month the individual becomes eligible for institutional care or Home and Community Based Services (HCBS) or the month of the transfer, whichever is later. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a denial notice. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.

(d) Any multiple transfers made within the look-back period will be treated as a single transfer and calculated as a single period of ineligibility, which would begin on the date the individual is eligible for medical assistance and would otherwise be receiving institutional level care if not for the imposition of the penalty period, or the date of transfer, whichever is later**.** For example, if an individual's spouse makes an

uncompensated transfer of assets of one thousand dollars ($1,000) in each of the sixty (60) months of the look-back period, the State would add the transfers together to arrive at a total amount of sixty thousand dollars ($60,000), divide that by the average private pay rate, and impose one continuous period of ineligibility. The penalty period would start with the earliest date specified under Tennessee's Medicaid plan.

(e) The transfers indicated below, if occurring on or after February 8, 2006, may be considered a transfer of assets for less than fair market value with respect to an individual applying for Medicaid based on institutionalization:

1. If the transfer of assets occurs within sixty (60) months of application for institutional care.

2. If the institutionalized individual, his/her spouse, or any person, court or administrative body with authority to act on behalf of, or at the direction or request of, the individual or his/her spouse, establishes a trust or similar device, which includes the individual's assets and cannot be used by or for the individual's benefit, if it occurred within sixty (60) months of application for institutional care.

3. If an asset is held jointly by the institutionalized individual with another person and the individual or other owner reduces or eliminates the institutionalized individual's ownership or control of the asset.

4. Penalty.

(i) The institutionalized individual may be subject to penalty if the transfer was completed by himself/herself; the individual's spouse; a person (including a court) or administrative body with legal authority to act in place of, or on behalf of, or at the direction or request of the institutionalized individual or his/her spouse.

(ii) The transfer of assets will be subject to a penalty period of ineligibility for nursing home vendor or waivered services under HCBS (Medicaid eligibility continues for other services) determined by dividing uncompensated value of the transferred asset by the average monthly nursing home charge at the private pay rate unless satisfactory proof is provided that the individual intended to dispose of assets for fair market value; or assets were transferred exclusively for a purpose other than to qualify for Medicaid; or transferred assets have been returned to the individual; or if it is determined that the penalty period would work an undue hardship as defined in (3)(b) above.

(iii) Assets include all income and resources, including the home, unless transferred as indicated in (a) above, of the institutionalized individual and his/her spouse (including income and/or resources the individual is entitled to, but does not receive because of any action by the individual or his/her spouse, or a person (including a court) or administrative body with legal authority to represent the individual, his/her spouse, or who acts at the direction or request of the individual and his/her spouse).

(f) Any contractual provision requiring the resident to deposit entrance fees must take into account the required allocation of resources or income to the community spouse before determining the resident's cost of care. In addition the entrance fee paid to the Continuing Care Retirement Community (CCRC) or life care community is treated as a

resource to an individual for purposes of determining Medicaid eligibility. The following three (3) conditions must all be met in order for the entrance fee to be considered an available resource:

1. Any portion of the entrance fee is refunded or used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient; and

2. The entrance fee, or any portion thereof, is refundable under the terms of the contract when the individual dies or terminates the contract and leaves the CCRC or life care community, whether or not any amount is actually refunded; and

3. The entrance fee does not confer an ownership interest in the community.

(g) Funds used to purchase a loan, mortgage or promissory note must be treated as a transfer of assets unless it has a repayment term that is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral or balloon payment, and prohibits cancellation of the balance upon the death of the lender. If an individual purchases a home from a nursing home applicant and the purchase agreement does not meet the criteria of this subparagraph (g)**,** the value of the home will be the outstanding balance due as of the date of the application for Medicaid.

(h) A life estate interest purchased by a nursing home applicant in another individual's home shall be treated as a transfer of assets unless the nursing home applicant resides in the home for a period of at least one (1) year after the date of the purchase.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. §§ 435.700, 435.721(b), 435.725, 435.735, 435.831, 435.832, and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (6) in its entirety and by substituting instead the following language so that, as amended, paragraph (6) shall read as follows:

(6) Undue hardship shall exist when an application of a transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered or of loss of food, clothing, shelter, or other necessities of life.

(a) The individual, the individual's responsible party, or the facility in which an institutionalized individual resides may file an undue hardship claim on behalf of the applicant/recipient. DHS will determine whether a hardship exists and notify the applicant/recipient within thirty (30) days of filing.

(b) If undue hardship is determined not to exist, the denial of undue hardship may be appealed within forty (40) days.

(c) While an application is pending for an undue hardship waiver and the applicant meets the criteria in 1240-3-3-.03 (6) above, the state will provide for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of ten (10) days.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, and 71-5-111; 42 U.S.C. §§ 1396 et seq., and 42 U.S.C. § 1396p(c)(2)(D) and (f)(4); and PL 109-171 §§ 6011 and 6014.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by inserting the following language as new paragraph (7) and renumbering the remaining paragraphs accordingly, so that, as amended, paragraph (7) shall read as follows:

(7) Annuities.

(a) For any new application or recertification for medical assistance for long-term care services, the applicant must include a description and disclosure of any interest the applicant or the community spouse may have in an annuity.

(b) The annuity must be treated as a transfer of assets unless it is irrevocable and non-assignable, actuarially sound, and provides payments in equal amounts during the term of the annuity, with no deferral or balloon payments.

(c) The purchase of an annuity will be treated as a transfer of assets for less than fair market value unless:

1. The State of Tennessee is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant. This provision applies to annuities purchased by an applicant or by a spouse, or transactions made by the applicant or spouse.

2. If there is a community spouse and/or a minor or disabled child, the State is named in the next position after those individuals.

(i) If the State has been named after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State may then be named in the first position.

(ii) A child is considered disabled if he or she meets the definition of disability found at Section 1614(a)(3) of the Social Security Act (42 U.S.C. § 1382c(a)(3)).

(d) In addition to the provisions in (c)1 or 2 above, an annuity purchased by or on behalf of the annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions in part 1 or part 2 or all of the conditions in part 3 below.

1. The annuity is –

(i) An individual retirement annuity according to section 408(b) of the Internal Revenue Code of 1986 (IRC) (26 U.S.C. § 408(b)), or

(ii) Deemed Individual Retirement Account (IRA) under a qualified employer plan according to section 408(q) of the IRC (26 U.S.C. § 408(q)), or

2. The annuity is purchased with proceeds from –

   (i) A traditional IRA (IRC § 408(a) (26 U.S.C. § 408(a)), or

   (ii) Certain accounts or trusts which are treated as traditional IRAs (IRC § 408 (c)) (26 U.S.C. § 408(c)), or

   (iii) Simplified retirement account (IRC § 408 (p)) (26 U.S.C. § 408(p)), or

   (iv) A simplified employee pension (IRC § 408 (k)) (26 U.S.C. § 408(k)), or

   (v) A Roth IRA (IRC § 408 A) (26 U.S.C. § 408(A)), or

3. The annuity meets all of the following—

   (i) The annuity is irrevocable and non-assignable,

   (ii) The annuity is actuarially sound, and

   (iii) The annuity provides payments in equal amounts, with no deferred or balloon payments.

4. If an annuity is absent of such proof as outlined in this subparagraph (d), the purchase of the annuity will be considered a transfer for less than fair market value which is subject to a penalty. The burden is on the institutionalized individual, or his or her representative, to produce the necessary documentation.

(e) The issuer of the annuity must notify the State when there is a change in the disbursement of income or principal from the annuity.

(f) The application for assistance, including the application for recertification, must include for long-term care services the required disclosure under Section 1917(e)(1) and (2) of the Social Security Act (42 U.S.C. § 1396p(e)(1) and (2)) as provided in subparagraph (a) above. Failure to complete an application form that meets these requirements will not affect the individual's eligibility for Medicaid; however, the individual will not be eligible for coverage of long-term care services unless the appropriate form is completed and signed.

(g) If the annuity is not subject to penalty as transferred assets, it must still be evaluated as income or resources, including spousal income or resources, and in the post-eligibility calculation, as appropriate.

1. A revocable annuity can be canceled and the funds used to purchase the annuity can be refunded to the purchaser. If the owner or payee may be changed, the annuity is assignable and can be sold on the secondary market.

   (i) If an annuity meets one or both of the criteria of revocable or assignable, it is a countable resource. If the annuity is revocable, the resource value is the amount that the purchaser would receive if the annuity is canceled. If the annuity is assignable, the resource value is the amount the annuity can be sold for on the secondary market.

   (ii) If an annuity purchased by or for an individual who has applied for medical assistance with respect to nursing facility or other long-term care

services is a countable resource, it is not treated as a presumptive transfer of assets for less than fair market value. However, assessing an annuity as a countable resource does not preclude an evaluation of the purchase of the annuity as a transfer of assets for less than fair market value if an assessment is warranted based on the circumstances. For example, if an assignable annuity is sold on the secondary market for less than its fair market value, a transfer of assets for less than fair market value may have occurred.

(h) The provisions of this paragraph (7) shall apply to all transactions occurring on or after February 8, 2006, including the purchase of an annuity and any other transaction that changes the course of payments to be made or the treatment of income and principal under an existing annuity, such as additions of principal, elective withdrawals, request to change the distribution of the annuity, elections to annuitize the contract and other similar actions.

(i) Routine changes which occur, based on the terms of an annuity which existed prior to February 8, 2006, and which do not require a decision, election, or action to take effect are not considered a transaction. Routine changes would also include an address change or death or divorce of a remainder beneficiary and other similar circumstances.

1. For example, if an annuity purchased in June 2001 included terms which require distribution to begin five years from the date of purchase, and payouts consequently begin, as scheduled, in June 2006, this will not be considered a transaction since no action was required to initiate the change.

2. Changes which are beyond the control of the individual, such as changes in law, a change in the policies of the issuer, or a change in terms based on other factors, such as the issuer's economic conditions, are not considered transactions.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-106, and 71-5-111; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(F) and (G), 42 U.S.C. § 1396p(d)(4)(B), and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4); 42 C.F.R. §§ 435.725 and 735 and 42 C.F.R. § 435.832; and PL 109-171 § 6012.

Rule 1240-3-3-.03 Resource Limitations for Categorically Needy, is amended by deleting newly numbered paragraph (9) in its entirety and by substituting the following language, so that, as amended, paragraph (9) shall read as follows:

(9) Assessment of Resources and Community Spouse Resource Allowance.

(a) Resources owned by either spouse, or by both spouses together, are considered equally available to both spouses at the beginning of a continuous period of institutionalization (i.e., 30 consecutive days in nursing care) for persons institutionalized after September 30, 1989. If an assessment of resources is requested by the institutionalized or community spouse or by either spouse's authorized representative, an assessment will be made within thirty (30) days of receipt of all relevant documentation from the requesting party(ies). If either spouse is dissatisfied with the Department's assessment of the community spouse's resource allowance at the point an application for Medicaid has been filed, either spouse has a right to a fair hearing with respect to the determination, which shall be held within thirty (30) days of the date a request for hearing is made.

(b) The community spouse resource allowance is equal to the greater of:

1. Effective January 1, 2008 one-half (1/2) of the total resources owned by both spouses not to be less than twenty thousand eight hundred eighty dollars ($20,880) nor greater than one hundred four thousand four hundred dollars ($104,400) and adjusted annually per federal law;

2. The amount established after a fair hearing by the Department of Human Services; or

3. The amount transferred under a court order against the institutionalized spouse for the support of the community spouse, using Tennessee's Medicaid eligibility standards, regardless of any other state laws relating to community property or the division of marital property.

(c) The maximum amount of income of the institutionalized spouse must be allocated to the community spouse before increasing the resource allocation.

(d) Spouses must be legally married pursuant to the laws of the State of Tennessee; and

(e) The community spouse resource allowance determined by the assessment will be deducted from the value of all available resources owned by both spouses as of the first month for which assistance is requested. After the initial month of eligibility, no resources of the community spouse will be considered available to the institutionalized spouse.

Authority: T.C.A. §§ 4-5-201 et seq., 71-1-105(11) and (12), 71-5-102, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D),(E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(c), (b), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. § 435.601 and 435.602, 42 C.F.R. §§ 435.700, 435.721(b), 435.725, 435.735, 435.831, 435.832, 435.840, 435.845, and 435.914 (b) and (c); PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 100-93 § 9; PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and OBRA 1993, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended to change the dollar amount of the personal needs allowance under paragraph (2), subparagraph (b), part 1 so that, as amended, part 1 shall read as follows:

1. Personal Needs Allowance: $40 for an individual.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102 and 71-5-147; and 42 U.S.C. § 1396a(a)(50) and (q).

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended to change the dollar amount of the Spousal/dependent allocation maximum under paragraph (2), subparagraph (b), part 2 so that, as amended, part 2, shall read as follows:

2. Effective January 1, 2008, spousal/dependent allocation not to exceed two thousand six hundred ten dollars ($2,610) per family, and adjusted annually per federal law, which includes:

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12) and 71-5-102; 42 U.S.C. § 1396a(a)(51); and 42 U.S.C. § 1396r-5(d).

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended to change the dollar amount of the personal needs allowance under paragraph (2), subparagraph (d), part 1 so that, as amended, part 1, shall read as follows:

1. Personal needs allowance: $40 for an individual.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102 and 71-5-147; and 42 U.S.C. § 1396a(a)(50) and (q).

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended by deleting the dollar values for the services rendered under paragraph (2), subparagraph (d), part 4, subparts (ii) and (iii) and to refer to the TennCare fee schedule as the allowable deduction so that, as amended, subparts (ii) and (iii), shall read as follows:

(ii) Eyeglasses and necessary related services. Deductions can only be made for the following services and must be the lesser of the provider's usual and customary charges, billed charges, or the amounts indicated in the TennCare fee schedule.

Examination and refraction
Frame
Lenses (bifocal)
Lenses (single)

(iii) Hearing aids and necessary related services. Deductions can only be made for the following services and must be the lesser of the provider's usual and customary charges, billed charges, or the amounts indicated in the TennCare fee schedule.

Audiogram
Ear mold
Hearing aid
Batteries
Hearing aid orientation

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12) and 71-5-102; and 42 U.S.C. §§ 1396 et seq.

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended by adding two (2) new subparts under paragraph (2), subparagraph (d), part 4, to be designated as (vi) and (vii), so that, as amended, paragraph (2), subparagraph (d), part 4, subparts (vi) and (vii) shall read as follows:

(vi) Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days when the recipient is away from the nursing facility are not allowable deductions. These charges are allowed only when the individual is in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). (TennCare allows a ten (10) day bed hold).

(vii) Charges incurred by the nursing facility for failure to timely submit or renew a previously submitted Pre-Admission Evaluation (PAE) are not allowable deductions.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12) and 71-5-102; and 42 U.S.C. §§ 1396 et seq.

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended by inserting the word overcharges in part 5, under paragraph (2), subparagraph (d) so that, as amended, paragraph (2), subparagraph (d), part 5 shall read as follows:

5. Patient liability overcharges adjustment.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12) and 71-5-102; and 42 U.S.C. §§ 1396 et seq.

Rule 1240-3-3-.04 Income Limitations For Categorically Needy, is amended by deleting subparagraph (h) (referring to Qualified Individuals 2 (Q1-2)) under paragraph (2) so that, as amended, paragraph (2) subparagraph (h) shall read as follows:

(h) Reserved.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-103, 71-5-106, 71-5-111, and 71-5-140; 42 U.S.C. § 1302, 42 U.S.C. §§ 1396a(a)(10) and 1396a(1), (q) and (r); 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396r-5, 42 U.S.C. §§ 1396r-5(b) and 5(d)(3)(B) and (C); 42 C.F.R. §§ 435.722, 435.726, 435.735, and 435.845; 42 C.F.R. §§ 435.725(d) as amended; 53 Federal Register 3586 (February 8, 1988); PL 100-203 § 4065, PL 99-272, PL 100-360 § 301, and PL 100-360 § 303.

Rule 1240-3-3-.05 Resource Limitations For The Medically Needy, is amended by renaming the rule "Resource Limitations For The Medically Needy And Standard Spend Down", by amending the Table of Contents accordingly, and by deleting the rule in its entirety and inserting the following language so that, as amended, Rule 1240-3-3-.05 shall read as follows:

1240-3-3-.05 Resource Limitations For The Medically Needy And Standard Spend Down.

(1) Applicants for medical assistance are permitted to retain resources in an amount not to exceed the SSI limits. An additional $100 in resources is allowed for each additional person in AFDC related coverage groups over those provided for in the SSI regulations.

(2) Excluded Resources.

(a) Resources excluded from consideration in the determination of eligibility for AFDC related medical assistance are those excluded in the Families First/AFDC cash assistance program in rule 1240-1-50-.05.

(b) Resources excluded from consideration for Standard Spend Down and institutionalized individuals who are aged, blind and disabled are those excluded by SSI regulations at 20 C.F.R. Part 416.

(3) Countable Resources.

(a) Countable resources for AFDC related cases are determined by using the policies of the Families First/AFDC cash assistance program as reflected in rule 1240-1-50-.06.

(b) Countable resources for Standard Spend Down and institutionalized individuals who are aged, blind and disabled are determined by using SSI policy at 20 C.F.R. Part 416 and as indicated in Rule 1240-3-3-.03(9) for institutionalized individuals with a spouse living in the community.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; 42 U.S.C. §§ 1396 et seq., 42 USC §1396r-5 and 42 U.S.C. § 1315; 42 C.F.R. § 435.845; 20 C.F.R. § 416.1205(c); PL 98-369 §2611, PL 99-272 §§ 9501 and 9506, PL 100-360 §303.

Rule 1240-3-3-.06 Income Limitations For The Medically Needy, is amended by renaming the rule "Income Limitations For The Medically Needy And Standard Spend Down", by amending the Table of Contents accordingly, and by deleting paragraph (1) in its entirety and by inserting the following language so that, as amended, paragraph (1) shall read as follows:

1240-3-3-.06 Income Limitations For The Medically Needy And Standard Spend Down.

(1) In medically needy cases for pregnant women and children under age twenty-one (21), countable income is determined by using the Families First/AFDC cash assistance program's income definitions and policies. Refer to Families First/AFDC income rules 1240-1-50-.08, 1240-1-50-.10 through 1240-1-50-.15, 1240-1-50-.16, and 1240-1-50-.17 through 1240-1-50-.19, with the following exceptions:

(a) The earned income disregard of thirty dollars ($30.00) plus one-third (1/3) of the remainder is granted in a medically needy case only if the applicant has received Families First/AFDC in at least one (1) of the last four (4) months. In such a situation the disregard is applied only for a four (4) month period.

(b) The maximum cap or gross income of one hundred eighty-five percent (185%) of the Families First/AFDC need standard does not apply to medically needy due to the spend-down provision.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; 42 U.S.C. §§ 1396 et seq., 42 USC §1396r-5 and 42 U.S.C. § 1315; 42 C.F.R. § 435.845; 20 C.F.R. § 416.1205(c); PL 98-369 §2611, PL 99-272 §§ 9501 and 9506, PL 100-360 §303.

Rule 1240-3-3-.06 Income Limitations For The Medically Needy And Standard Spend Down, is amended to insert the phrase "Families First Handbook" in the place of the phrase "AFDC Manual" in the parenthesis under subparagraph (a) of paragraph (3) so that, as amended, paragraph (3), subparagraph (a) shall read as follows:

(3) Determination of countable income of an individual or family.

(a) The countable income of an individual or family, once determined, is tested against the following standard, depending upon the number of individuals for whom application is made:

Size of Family	Monthly
1	Two hundred forty-one dollars ($241) (effective July 1, 1999)
2 and above	One hundred thirty-three and one-third percent (133 1/3%) of the maximum money payment which could be made to a family of the same size under Families First/AFDC

(Refer to Families First Handbook for payment levels and ratably reduced standard of need.)

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; 42 U.S.C. §§ 1396 et seq., 42 USC §1396r-5 and 42 U.S.C. § 1315; 42 C.F.R. § 435.845; 20 C.F.R. § 416.1205(c); PL 98-369 §2611, PL 99-272 §§ 9501 and 9506, PL 100-360 §303.

Rule 1240-3-3-.06, Income Limitations For The Medically Needy And Standard Spend Down, is amended by deleting paragraph (4) in its entirety and by substituting instead the following language, so that as

amended, paragraph (4) subparagraph (a) and (b) shall read as follows:

1240-3-3-.06 Income Limitations For The Medically Needy and Standard Spend Down.

(4) Countable medical or remedial expenses for determination of spenddown eligibility.

(a) Medical and remedial expenses that remain unpaid, have not been written off by the health care provider, and that are the client's responsibility, may, pursuant to this paragraph (4), be applied to any excess income to reduce income in order to qualify for eligibility in the spenddown category.

(b) For new applicants during open enrollment periods as announced by the Bureau of TennCare or persons currently Exceptionally Eligible who did not meet spenddown criteria in order to qualify during their last eligibility determination, the following medical/remedial expenses will be counted toward the reduction of income in the Standard Spend Down coverage group:

1. Expenses incurred during the month of application, whether paid or unpaid;

2. Expenses paid during the month of application, regardless of when such bills were incurred;

3. Expenses incurred during the three (3) calendar months prior to the month of application whether paid or unpaid.

(i) Expenses paid during the three (3) calendar months prior to the month of application will not be counted unless such expenses were also incurred during those three (3) calendar months.

(ii) Any expenses incurred before the three (3) calendar months prior to the month of application will not be counted unless payment is made on those expenses during the month of application, in which case only the amount paid during the month of application is counted.

(iii) When any new applicants apply again after their first year of eligibility, countable medical or remedial expenses will be limited to the expenses incurred or paid as described in parts 1, 2 and 3(i) and (ii) to expenses for the new month of application and three (3) calendar months prior to the new month of application, plus any unpaid expenses that were previously verified and documented as part of this new spenddown process, i.e., only those expenses incurred or paid during the month of application and expenses incurred during the three (3) calendar months prior to that month of application. Verified expenses can be carried over as long as the individual remains continuously eligible, the expenses remain unpaid and are not written off by the provider. If the individual loses eligibility at any point, or if the individual ever qualifies as Exceptionally Eligible in the future, the carryover of unpaid medical expenses ends, and the individual is limited to the expenses listed in subparagraph (b)1, 2 and 3(i) and (ii).

(iv) When an Exceptionally Eligible individual re-applies, no carryover of expenses is permitted because spenddown criteria were not required to qualify as Exceptionally Eligible, and the individual is limited to the expenses listed in (b)1, 2, and 3(i) and (ii). If thereafter, the individual does have to meet spenddown criteria to re-qualify, then, for the continuous eligibility period thereafter, applicable expenses that were

verified and documented in any eligibility determination, after the period in which the person qualified as Exceptionally Eligible, that remain unpaid will be counted. Any medical/remedial expenses that otherwise may have been used to qualify for medically needy coverage under spenddown criteria in the period prior to the period in which the individual did not have to meet spenddown criteria to qualify for medically needy coverage cannot be carried over in order to establish eligibility.

(c) For current medically needy eligibles, the following medical/remedial expenses will be counted toward the reduction of income in medically needy coverage groups:

1. Expenses incurred during the month of application, whether paid or unpaid;

2. Expenses paid during the month of application, regardless of when such bills were incurred;

3. Expenses incurred during the three (3) calendar months prior to the month of application; whether paid or unpaid.

(i) Expenses paid during the three (3) calendar months prior to the month of application will not be counted unless such bills were also incurred during those three (3) calendar months.

(ii) Any expenses incurred before the three (3) calendar months prior to the month of application will not be counted unless:

(I) Payment is made on those expenses during the month of application, in which case only the amount paid during the month of application is counted; or

(II) All of the following are satisfied:

I. Those expenses were previously verified in order to meet spenddown criteria;

II. The individual has remained continuously eligible in a spenddown category since that time;

III. The individual met a spenddown criteria during each period of eligibility in order to qualify; and

IV. The expenses remain unpaid and have not been written off by the provider.

A. When the circumstances of subitem (II)IV exist, the carryover that has not been previously deducted from income for purposes of qualifying for spenddown can be applied. The carryover expense can include an unused portion or an entirely unpaid expense.

B. Only in cases of individuals who are currently eligible, expenses incurred before the three (3) calendar months prior to the initial month of application may be carried over, but only unpaid

expenses that were previously verified and documented in the DHS eligibility data system as part of the spenddown process will be counted. Expenses that had not been provided earlier to determine eligibility cannot be counted.

C. To be counted, the expenses must have remained unpaid, and only the portions not used earlier to qualify under spenddown criteria are counted.

4. Not all expenses incurred during the entire continuous eligibility period will be counted towards spenddown eligibility. Only expenses identified in (c)1, 2 and 3 above including qualifying carryover expenses from earlier spenddown determinations will be counted.

5. When a gap in eligibility occurs or there is any period of eligibility in which the individual has no excess income, the individual must re-qualify under subparagraph (b) above.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102 and 71-5-109; 42 U.S.C. §§ 1396 et seq. and 42 U.S.C. § 1315; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Rule 1240-3-3-.06 Income Limitations For The Medically Needy And Standard Spend Down, is amended by deleting paragraph (5) in its entirety and by substituting the following language, so that as amended, paragraph (5) shall read as follows:

(5) Patient liability for institutionalized individuals whose gross income exceeds the categorical Medicaid income cap and the individual has established a qualified income trust will be determined by using the deductions listed within rule 1240-3-3-.04(2)(d) and by comparing the remainder to the Medicaid reimbursement rate for the long-term care being provided.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, and 71-5-109; 42 U.S.C. §§ 1396 et seq., 42 USC §1396r-5 and 42 U.S.C. § 1315; 42 C.F.R. § 435.845; 20 C.F.R. § 416.1205(c); PL 98-369 §2611, PL 99-272 §§ 9501 and 9506, PL 100-360 §303.

Legal Contact or Party who will approve final copy:

Phyllis Simpson
Assistant General Counsel
Citizens Plaza Building, 10th Floor
400 Deaderick Street
Nashville, Tennessee 37243-1403
(615) 313-4731

Contact for disk acquisition:

Alan Buescher
Legal Assistant
Citizens Plaza Building, 10th Floor
400 Deaderick Street
Nashville, Tennessee 37243-1403
(615) 313-4731

I certify that this is an accurate and complete representation of the intent and scope of rulemaking proposed by the Department of Human Services.

Phyllis A. Simpson
Assistant General Counsel
Tennessee Department of Human Services

Subscribed and sworn to before me this 28th day of Dec., 2007.

REGINA D. MITCHELL
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires MAY 24, 2008

Regina D. Mitchell
Notary Public

My commission expires on the 24th day of May, 2008

The notice of rulemaking set out herein was properly filed in the Department of State on the 28 day of Dec, 2007.

Riley C. Darnell
Secretary of State

By: _____

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